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IN OR OUT: CALCULATION OF THE MEDICAL LOSS RATIO AND ITS EFFECT ON THE AFFORDABLE CARE ACT

Abstract: On March 18, 2019, the United States Court of Appeals for the Ninth Circuit held, in *Morris v. California Physicians' Service*, that when calculating the Medical Loss Ratio (MLR) provision of the Patient Protection and Affordable Care Act (ACA), there is no distinction between services from in-network or out-of-network providers. Specifically, the Ninth Circuit held that the numerator of the MLR may include out-of-network services as part the insurance company's incurred claims. The Ninth Circuit was the first to interpret the MLR provision and address whether there was any basis in the language or spirit of the ACA to narrowly read the MLR provision. This Comment argues that the Ninth Circuit's broad interpretation properly promotes the core values behind the enactment of the ACA.

INTRODUCTION

Enacted in 2010, the Patient Protection and Affordable Care Act (ACA) has the principal objectives of increasing the American population's health insurance coverage and decreasing health care costs.¹ In *Morris v. California Physicians' Service*, the United States Court of Appeals for the Ninth Circuit considered these two core values when, in a 2019 case of first impression, it interpreted the parameters of the Medical Loss Ratio (MLR) provision.²

¹ See Patient Protection and Affordable Care Act, 42 U.S.C. §§ 18001–18122 (2018); Nat'l Fed'n of Indep. Bus. v. Sebelius (*NFIB*), 567 U.S. 519, 538 (2012). On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (ACA), which is often regarded as one of the most influential pieces of health-care legislation since the formation of Medicare and Medicaid. Scott E. Harrington, *U.S. Health-Care Reform: The Patient Protection and Affordable Care Act*, 77 J. RISK & INS. 703, 703 (2010).

² See *Morris v. Cal. Physicians' Serv.*, 918 F.3d 1011, 1012, 1019–20 (9th Cir. 2019) (stating that the Medical Loss Ratio (MLR) provision further promotes the core values of the ACA and incentivizes insurance companies to focus their spending on clinical services). Clinical services include professional services provided in outpatient clinics, establishments owned by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), or certain medical or diagnostic laboratories that can independently bill. CTRS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURE ACCOUNTS: METHODOLOGY PAPER, 2017, at 10 (2017), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/dsm-17.pdf> [<https://perma.cc/YEP6-68ZN>]. Clinical services also include those provided by an M.D. or D.O in a hospital and are considered to be part of the hospital services estimate. *Id.* Examples of clinical services include emergency care, mental health services, pediatric care, and surgery and anesthesia. *Clinical Services*, WORLD HEALTH ORG., <http://www.who.int/hospitals/clinical-services/en/> [<https://perma.cc/MJ3M-PDLF>].

Congress implemented the MLR provision with the purpose of lowering of health care costs by requiring insurance companies to provide clear accounting of these costs and ensuring that insurance enrollees receive value for their premium payments.³ The MLR provision requires that eighty-percent of an insurance company's spending go towards clinical services and health care quality improvement.⁴ If an insurance company fails to meet this threshold, it must send its policyholders a rebate of the difference between the amount it spent on clinical services and the eighty-percent value.⁵

As the MLR is a ratio, its calculation involves a numerator and a denominator.⁶ The numerator consists of the amount an insurer spent on incurred claims plus the amount it spent on activities improving health care

³ 42 U.S.C. § 300gg-18 (2018). The ACA gives the Secretary of the Department of Health and Human Services (HHS) direct enforcement authority for the MLR provision. *Id.* § 300gg-18(b)(3); CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAL LOSS RATIO: GETTING YOUR MONEY'S WORTH ON HEALTH INSURANCE (2010), <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/medical-loss-ratio.html> [<https://perma.cc/Z36R-JPAB>]. HHS has since recognized the role that states play in assisting with enforcement and will accept the findings of a state audit. *Id.* The MLR provision promotes the clear accounting of costs because it requires insurance companies to provide to HHS an annual report on how they spent premium revenue. 42 U.S.C. § 300gg-18(a); CTRS. FOR MEDICARE & MEDICAID SERVS., *supra*. In the reports, insurance companies have to include the total earned premiums, total reimbursement for clinical services, total spending on activities to improve quality, and total spending on all other non-claim costs other than federal and state taxes and fees. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra*. Activities that improve quality are those that increase the likelihood of desired health outcomes. *Id.* Enrollees in each state can access insurance companies' public reports to see how insurers utilize their premium fees. *Id.* Specifically, enrollees are able to compare how much the insurance company spent on clinical services and improving health care versus how much it spent on administrative costs such as executive salaries and bonuses, advertising, and marketing. *Id.*

⁴ 42 U.S.C. § 300gg-18(b)(1)(A)(ii). In order for an activity to be considered one that improves health-care quality, it must be backed by evidence, account for the specific needs of patients, and objectively increase desired health outcomes. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 3. To continue to foster innovation, however, the MLR provision does not require insurance companies to provide initial evidence to designate an activity as improving health-care quality. *Id.* If the insurance company wants to continue claiming the activity as quality improving, the company must objectively show noticeable results from the activity. *Id.*

⁵ 42 U.S.C. § 300gg-18(b)(1)(B)(i). The Centers for Medicare and Medicaid Services (CMS) has estimated that the MLR provision will affect up to 74.8 million Americans, and roughly 9 million Americans will be eligible to receive rebates totaling \$1.4 billion. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 3. CMS has also estimated that an individual could receive an average rebate of \$164 annually. *Id.* If an insurance company does not comply with the MLR requirements, HHS can impose civil monetary penalties. *Id.* Violations of the MLR provision are subject to a penalty of \$100 per entity, per day, for each individual affected by the violation. *Id.*

⁶ See *Medical Loss Ratio—Overview*, UNITEDHEALTHCARE (Aug. 16, 2016), https://www.uhc.com/content/dam/uhcdotcom/en/HealthReform/PDF/Provisions/MedicalLossRatio_Basics.pdf [<https://perma.cc/PPH2-7BSN>] (providing the components of the MLR calculation). HHS worked with the National Association of Insurance Commissioners (NAIC) to establish the methodology for calculating the MLR. *Id.* Calculation of the MLR is not based on an individual's policy, but instead on the aggregate performance of a health plan. SUZANNE M. KIRCHHOFF, CONG. RESEARCH SERV., MEDICAL LOSS RATIO REQUIREMENTS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA): ISSUES FOR CONGRESS 1, 16 (2013).

quality.⁷ The denominator consists of the total premium revenue collected from policyholders, less taxes, licensing fees, and regulatory fees.⁸ The main point of contention in *Morris* was whether payments for services by out-of-network providers should be included as incurred claims in the numerator.⁹ The Ninth Circuit held that there was no reason for excluding payments for out-of-network services in the MLR calculation and, thus, that the payments must be accounted for in the numerator of the MLR.¹⁰

This Comment argues that, in ruling that there is no distinction between in-network and out-of-network services for calculating the MLR numerator, the Ninth Circuit properly upheld the core values of the ACA.¹¹ Part I discusses the legal and factual context of *Morris*.¹² Part II describes the arguments against including claim adjustments for out-of-network service as incurred claims in the MLR numerator.¹³ Part III supports the Ninth Circuit's ruling that there should be no distinction between in-network and out-of-network services when calculating the MLR.¹⁴

⁷ UNITEDHEALTHCARE, *supra* note 6. Incurred claims are also known as medical claims, health-care benefits, or clinical services. KIRCHHOFF, *supra* note 6, at 6. The amount spent on incurred claims includes the direct claims incurred, any unpaid claim reserves associated with the claims incurred, claims-related portion of reserves for contingent benefits and lawsuits, and experience-rated refunds. *Id.* In addition, HHS agreed with the NAIC's recommendation that prescription drug costs should be part of the calculation of the incurred claims amount. *Id.*

⁸ UNITEDHEALTHCARE, *supra* note 6. Premium revenue is the total of any fee or contribution that a policyholder has paid to obtain coverage under the insurance company's health plan. KIRCHHOFF, *supra* note 6, at 10. Under the MLR provision, there are some exclusions in calculating earned premiums, such as premium assets paid to federal and state high-risk insurance pools, adjustments for retroactive rate reductions, and reinsurance. *Id.* Retroactive rate reductions occur when the initial premium is merely an estimation but the final premium is based on actual claims made while the policy was in place. *Id.* at 10 n.33. Reinsurance is essentially insurance for insurers where the reinsurers charge a premium to the original insurance company for all or part of the losses that the original insurer may incur. *Id.* at 10 n.35. Federal taxes that are subtracted from the denominator are all federal taxes associated with health insurance coverage, but taxes on investment income and capital gains are not subtracted from the denominator. *Id.* at 11. HHS also requires that insurance companies report state taxes separately from federal taxes. *Id.* Licensing and regulatory fees include any statutory assessments and examination fees paid in place of premium taxes but do not include regulatory fines and penalties. *Id.*

⁹ *Morris*, 918 F.3d at 1018. Medical providers, such as doctors or hospitals, are in-network when they accept the enrollee's health insurance plan. See *What's the Difference Between In Network and Out of Network?*, BLUE CROSS BLUE SHIELD OF MICH., <https://www.bcbsm.com/index/health-insurance-help/faqs/topics/how-health-insurance-works/difference-between-in-network-out-of-network-benefits.html> [<https://perma.cc/QK5K-6TFC>] (explaining that in-network providers agree to an approved billing amount, which the insurance company determines, for services provided). If providers do not accept an enrollee's health insurance plan, insurance companies consider them out-of-network providers. *Id.*

¹⁰ See *Morris*, 918 F.3d at 1020 (stating that there is no indication from either the phrasing or purpose of the ACA to narrowly construe the incurred-claims calculation of the MLR).

¹¹ See *infra* notes 79–90 and accompanying text.

¹² See *infra* notes 15–62 and accompanying text.

¹³ See *infra* notes 63–78 and accompanying text.

¹⁴ See *infra* notes 79–90 and accompanying text.

I. LEGAL AND FACTUAL CONTEXT BEHIND *MORRIS*

Section A of this Part provides an overview of the purpose behind the ACA and its changes to the insurance market.¹⁵ Section B examines the MLR provision of the ACA, focusing on how the ratio is calculated.¹⁶ Section C presents the factual and procedural history of *Morris v. California Physicians' Service*.¹⁷

A. The Patient Protection and Affordable Care Act: Purpose and Reform

The ACA addresses the high health care costs, high uninsured population, and health disparities in the United States.¹⁸ To tackle these issues, the ACA requires individuals to obtain health coverage, subsidizes the cost of coverage for lower income individuals, requires small employers to offer coverage, and expands eligibility for Medicaid.¹⁹

As part of the insurance market reforms, the ACA departed from the traditional private health insurance marketplace and instead requires each state to establish its own American Health Benefit Exchange (exchange).²⁰ Exchanges serve as online marketplaces where individuals without employer-based coverage and small businesses can compare and purchase health insur-

¹⁵ See *infra* notes 18–23 and accompanying text.

¹⁶ See *infra* notes 24–34 and accompanying text.

¹⁷ See *infra* notes 35–62 and accompanying text.

¹⁸ AM. PUB. HEALTH ASS'N, *WHY DO WE NEED THE AFFORDABLE CARE ACT?* 1–2 (2017) https://www.apha.org/~media/files/pdf/topics/aca/why_need_aca_2017.ashx [<https://perma.cc/Q4LH-8BR4>]. See generally 42 U.S.C. § 18001 (aiming to provide quality and affordable health care for all Americans). In 2014, Medicare consisted of fourteen percent of the federal budget and that percentage continues to increase as the baby boom generation ages. AM. PUB. HEALTH ASS'N, *supra*, at 1. Prior to the enactment of the ACA in 2012, 16.6% of the population under sixty-five lacked medical insurance. *Id.* This is an issue because those that are uninsured are unlikely to seek preventative care or seek care immediately when ill. *Id.* Additionally, they will pay higher costs when they seek care. *Id.*

¹⁹ See Frederik Thide, Comment, *In Search of Limiting Principles: The Eleventh Circuit Invalidates the Individual Mandate in Florida v. U.S. Department of Health and Human Services*, 53 B.C. L. REV. 359, 359 (2012), <https://lawdigitalcommons.bc.edu/bclr/vol53/iss1/9> [<https://perma.cc/A8RW-BEK2>] (explaining that the ACA requires citizens to maintain insurance in order to achieve universal access to health care); Harrington, *supra* note 1, at 704. The individual mandate requires most legal residents to enroll in health insurance, unless the premium costs exceed 8% of their incomes. Harrington, *supra* note 1, at 704. The mandate currently still stands, but Congress repealed the federal penalty that enforced compliance in 2017. Tax Cuts and Jobs Act, Pub. L. No. 115-97, 131 Stat. 2054, 2092 (2017). Families or individuals who live between 133–400% of the federal poverty level are entitled to premium credits to reduce the cost of coverage. Harrington, *supra* note 1, at 704. The ACA requires employers with more than fifty employees to offer a health insurance policy to their employees, or they will face a penalty. *Id.* The ACA expands Medicaid eligibility to people with an income up to 133% of the federal poverty level. *Id.*

²⁰ 42 U.S.C. § 10831(b)(1) (2018); see Harrington, *supra* note 1, at 707 (predicting that the creation of government-regulated exchanges would transform the current private market).

ance plans.²¹ An exchange simplifies choosing an insurance plan and ensures transparency because it identifies qualified insurance plans and rates them according to their quality and price.²² Consumers may also apply for premium tax credits and cost-sharing reductions through an exchange.²³

B. The Medical Loss Ratio Provision: Purpose and Calculation

The MLR provision of the ACA plays an important role in lowering health care costs by requiring insurers to provide an accounting of costs and by ensuring that enrollees receive value for their premium payments.²⁴ The MLR provision requires insurers to submit a report each plan year to the Department of Health and Human Services (HHS).²⁵ The report must detail the ratio of the incurred claims and any adjustments to expenses to the total collected premiums.²⁶ Specifically, the numerator of the ratio includes incurred claims, and insurance companies may add quality improvement expenses if applicable.²⁷ An incurred claim is a direct claim that the insurance company

²¹ See 42 U.S.C. § 10831(b)(1) (explaining that the exchanges would be useful for consumers to research and purchase qualified health plans); *King v. Burwell*, 135 S. Ct. 2480, 2487 (2015) (describing the ACA's requirement that each state establish a marketplace for individuals and small businesses to shop for private insurance plans online). If a state fails to establish an exchange, the Secretary of HHS will establish one and operate it instead. 42 U.S.C. § 18041(c)(1) (2018).

²² See Stephen H. Gorin, *The Affordable Care Act: Background and Analysis*, 36 HEALTH & SOC. WORK 83, 84 (2011) (explaining that the purpose of the exchanges is to enable individuals to obtain coverage on an informed basis because they provide the quality and price of a plan's benefits and monitor any premium increases).

²³ See VANESSA C. FORSBERG, CONG. RESEARCH SERV., R44065, OVERVIEW OF HEALTH INSURANCE EXCHANGES 1 (2018) (explaining that consumers participating in an exchange may be eligible to receive income-based financial assistance). The premium tax credit helps reduce the cost of health insurance. *Id.* Although the credit is generally available to all consumers who cannot access public or employment-based coverage meeting specified standards, individuals with lower incomes are likely to receive more credit than those with higher incomes. *Id.* at 5–6. Consumers can also lower the cost of coverage by applying for cost-sharing reductions, which lower out-of-pocket expenses by either reducing the annual out-of-pocket limit or reducing the percentage of costs the consumer is responsible for. *Id.* at 6.

²⁴ 42 U.S.C. § 300gg-18(a), (b); see *Morris*, 918 F.3d at 1013, 1016 (explaining that the MLR provision decreases the cost of health care by encouraging the use of premium revenue on health-care related expenses rather than on administration and marketing expenses and profit).

²⁵ 42 U.S.C. § 300gg-18(a), (b).

²⁶ *Id.* § 300gg-18(a). Insurance companies set contract reserves to account for the value of future benefit payments, which is subject to change. KIRCHHOFF, *supra* note 6, at 7. Contract reserves that are set aside at the start of an insurance plan are subsequently used to cover claims as the plan matures. *Id.*

²⁷ UNITEDHEALTHCARE, *supra* note 6. Incurred claims are payments that the insurance company makes for clinical services provided to the enrollees. 42 U.S.C. § 300gg-18(a)(1); *Explaining Health Care Reform: Medical Loss Ratio (MLR)*, HENRY J KAISER FAMILY FOUND. (Feb. 29, 2012), <https://www.kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/> [<https://perma.cc/HY7D-PYU8>] [hereinafter HENRY J KAISER FAMILY FOUND.]. Quality improvement expenses are activities that improve the quality of health care. 42 U.S.C. § 300gg-18(a)(2). There are four specific requirements for an activity to qualify as a quality improvement expenditure. KIRCH-

pays on behalf of an enrollee for clinical services or supplies that the health insurance plan covers.²⁸ The denominator includes earned premiums less any taxes, licensing fees, and regulatory fees.²⁹ The MLR provision requires insurance companies to disclose the percentage of premium revenue spent on medical benefits, health care quality improvement, and other administrative expenses or profits.³⁰ In reporting incurred claims, the statute does not expressly differentiate between out-of-network and in-network services.³¹

The MLR provision requires that insurance companies issue a rebate to their policy holders if their numerator is less than eighty-percent of the de-

HOFF, *supra* note 6, at 7–8. First, the activity must show improvements in patients' health outcomes. *Id.* at 7. Activities that improve health outcomes can include increasing quality reporting, efficient case management, quality care coordination, and continuing management of chronic diseases. *Id.* Second, the activity must reduce hospital readmissions through methods like patient education, discharge planning, and post-discharge follow-ups. *Id.* Third, the activity must increase patient safety and decrease medical errors. *Id.* at 8. This can be achieved through enforcement of best clinical practices, evidence-based medicine, and health information technology. *Id.* Lastly, the activity must encourage patient wellness and promote general health. *Id.*

²⁸ 45 C.F.R. § 158.140(a) (2019). Generally, an increase in incurred claims and quality improvement expenses will increase the MLR. KIRCHHOFF, *supra* note 6, at 6. When the MLR increases, the likelihood that enrollees receive rebates is lower, because insurance companies are more likely to reach the eighty-percent threshold. *Id.* Although enrollees are less likely to receive a rebate when there is an increase in incurred claims and quality improvement expenses, the primary goals of the ACA are likely still met because more of the insurance company's premiums go towards reimbursing clinical services and activities that improve the quality of health care. See CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 3 (describing how the MLR requirement incentivizes insurers to focus premium dollars on reimbursing medical claims). If there are reductions in the amount spent for incurred claims or improvement of health care quality, the MLR will decrease. KIRCHHOFF, *supra* note 6, at 6. A decrease in the MLR results in an increased chance that the insurance company will have to provide enrollees a rebate. *Id.*

²⁹ 42 U.S.C. § 300gg-18(a)(3). Premiums are the revenue earned from consumers purchasing the insurance plan. HENRY J KAISER FAMILY FOUND., *supra* note 27. Federal, state, and local taxes are subtracted, but taxes on investment income and capital gains are not. *Id.* Typically, if the numerator stays constant, an increase in earned premiums lowers the MLR. KIRCHHOFF, *supra* note 6, at 10. Conversely, a decrease in earned revenue, while expenses stay constant, will raise the MLR. *Id.* Increasing the MLR decreases the likelihood that an insurance company will have to provide enrollees a rebate, because the insurance company is more likely to spend eighty-percent of its revenue on clinical services and quality improvement expenses. *Id.*

³⁰ 42 U.S.C. § 300gg-18(a); see KIRCHHOFF, *supra* note 6, at 1. (explaining that the basic function of the MLR is to measure the share an insurance company spends on medical benefits as opposed to other company expenses). Although there are state laws that expand on the MLR provision, the ACA's provision is the minimum standard that certain health insurers nationwide must meet. KIRCHHOFF, *supra* note 6, at 1. For-profit, fully funded health insurers offering coverage must comply with the MLR requirements. *Id.* at 3–4. Non-profit insurers must also report their MLR and meet the requirements to maintain non-profit status. *Id.* at 4. There are different standards for Medicare Part D prescription drug plans and Medicare Advantage Plans. *Id.* Also, the MLR provision does not apply to any health care plans that are self-funded, meaning that the employers assume the risk for medical care. *Id.*

³¹ 45 C.F.R. § 158.140(a), (b); *Morris*, 918 F.3d at 1016.

nominator.³² If insurers do not meet the eighty-percent benchmark, they must refund the difference between the amount spent and that benchmark to their enrollees.³³ The rebate furthers the goals behind the ACA as it ensures that enrollees receive value for their premium payments and helps lower the cost of coverage.³⁴

C. Morris's Factual and Procedural History

As part of its implementation of the ACA's requirements, the State of California selected Blue Shield to be one of the insurance providers on its new health insurance exchange, Covered California.³⁵ Consumers who pur-

³² 42 U.S.C. § 300gg-18(b)(1)(A); *Morris*, 918 F.3d at 1013. For large-group insurance plans, the MLR benchmark is 85%, as opposed to 80% for individual and small-group plans. 42 U.S.C. § 300gg-18(b)(1)(A)(i); (b)(1)(A)(ii). The ACA considers three different markets: the large-group market, small-group market, and individual market. KIRCHHOFF, *supra* note 6, at 3. The large-group market is for employers' group policies when there are more than one-hundred workers. *Id.* The small-group market sells policies for employers with up to one-hundred employees. *Id.* For employer-sponsored insurance, whether large or small, the employer receives the rebate and apportions it to the employees based on their portion of the premium payment. *Id.* at 16. For individual insurance, the insurer will directly pay the rebate to the enrollee. *Id.* If a policy, individual or employer-based, only covers an enrollee for a part of the calendar year, the rebate is prorated accordingly. *Id.*

³³ 42 U.S.C. § 300gg-18(b)(1)(B); *Morris*, 918 F.3d at 1013. If a provider fails to meet the eighty-percent requirement, it must notify its policyholders of the rebate. HENRY J KAISER FAMILY FOUND., *supra* note 27. Insurance companies must issue any rebates by August first using the MLR calculated for the previous calendar year. KIRCHHOFF, *supra* note 6, at 16. HHS has defined an enrollee to include any person or entity that has paid a premium to receive health-care coverage during the relevant calendar year. *Id.*

³⁴ 42 U.S.C. § 300gg-18(b); see MARK A. HALL & MICHAEL J. MCCUE, HOW THE ACA'S MEDICAL LOSS RATIO RULE PROTECTS CONSUMERS AND INSURERS AGAINST ONGOING CERTAINTY 2 (2019), <https://www.commonwealthfund.org/publications/issue-briefs/2019/jul/how-aca-medical-loss-ratio-rule-protects-consumers-insurers> [<https://perma.cc/LV6B-LS2G>] (explaining that the MLR rebate prevents excessive profits for insurance companies and protects consumers against overpriced health-care plans).

³⁵ *Morris*, 918 F.3d at 1016. California established Covered California after the passage of the ACA and officially began enrollment on October 1, 2013 for the first open-enrollment period. Richard M. Scheffler et al., *Covered California: The Impact of Provider and Health Plan Market Power on Premiums*, 40 J. HEALTH POL. POL'Y L. 1179, 1180 (2015). Covered California offered eleven health plans in 2014, including Blue Shield of California, Anthem Blue Cross of California, Health Net, and Kaiser Permanente. *Id.* These four insurers composed of ninety-three percent of the statewide market share in Covered California during its first policy year. *Id.* Consumers could enroll in the health plan of their choice through Covered California. *Id.* Most insurers offered an array of policies, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), or exclusive provider organizations (EPOs). *Id.* Blue Shield offered PPO and EPO individual and family (IPF) plans. Brief for Appellee at 10, *Morris*, 918 F.3d 1011 (No. 2:16-cv-05914-JAK), 2018 WL 734016, at *10. If an enrollee purchases a PPO plan, the enrollee pays less for providers within the plan's network. *Id.* If the enrollee uses a provider outside the network, the enrollee will incur additional costs. *Id.* In an EPO, there is a single network and out-of-network services are not covered at all, unless it is emergency or plan-approved care. *Id.* at 11.

chased insurance plans with Blue Shield could search for in-network health care providers in an online directory.³⁶

Issues arose when Blue Shield enrollees found out that some providers listed as in-network providers in the directory did not accept their insurance.³⁷ In late 2013, enrollees filed a complaint with the California Department of Managed Health Care (DMHC).³⁸ DMHC conducted a formal survey of Blue Shield's entire provider directory and found that approximately nine percent of the physicians listed as in-network providers in the online directory were not in-network.³⁹

Due to this error, a portion of Blue Shield's enrollees received clinical services from providers that were out-of-network, erroneously thinking they were in-network providers.⁴⁰ Because the providers were out-of-network, the enrollees were responsible for paying more out of pocket for their medical care.⁴¹

To resolve the issue, Blue Shield entered into a settlement agreement with DMHC.⁴² Blue Shield agreed to reprocess claims and compensate enrollees who paid out-of-network rates for providers that Blue Shield mistakenly listed as in-network.⁴³ Blue Shield ultimately paid \$38 million in claims ad-

³⁶ *Morris*, 918 F.3d at 1016. Blue Shield enrollees could also call customer service representatives to find in-network providers and acquire their information. *Id.* The customer service representatives help the insured to select from Blue Shield's directory a physician that participated as an in-network provider and to identify physicians considered out-of-network providers. *Id.*

³⁷ *Id.* at 1016–17.

³⁸ *Id.* at 1016. The California Department of Managed Health Care (DMHC) is the governing body that regulates California's health-care plans. *Id.* DMHC is charged with protecting consumers' health-care rights and maintaining proper functioning of the health-care delivery system. *About the DMHC*, DEP'T OF MANAGED HEALTH CARE, <https://www.dmhc.ca.gov/AbouttheDMHC.aspx> [<https://perma.cc/UVK6-6Y5M>]. In response to the enrollees' complaint, DMHC conducted an informal survey of randomly selected providers listed as in-network in the Blue Shield directory. *Morris*, 918 F.3d at 1016. It found that many provider offices did not accept Covered California despite being listed as an approved provider on Blue Shield's directory. *Id.* at 1017.

³⁹ *Morris*, 918 F.3d at 1017. DMHC began a formal survey of Blue Shield's entire directory after finding, through the informal survey, that several of the listed providers did not accept Covered California. *Id.* at 1016. Because of Blue Shield's mistake, some enrollees had to pay more out of pocket for the medical services they received than they would usually pay if the provider was in-network. *Morris v. Blue Shield of Cal. (Blue Shield)*, No. 16-05914, 2017 WL 1653938, at *2 (C.D. Cal. May 1, 2017), *aff'd* 918 F.3d 1011 (9th Cir. 2019).

⁴⁰ Brief for Appellee, *supra* note 35, at 11–12. Under either Blue Shield's PPO or EPO plan, enrollees would not incur any bill, or would incur only a smaller bill, if they obtained medical care from an in-network provider. *Id.* at 10–11.

⁴¹ Brief for Appellee, *supra* note 35, at 11–12.

⁴² *Id.* at 12.

⁴³ *Morris*, 918 F.3d at 1017. Blue Shield recognized that it had mistakenly listed out-of-network providers as in-network, resulting in confusion and increased out-of-pocket expenses for enrollees. *Id.* Under Exhibit A of the settlement agreement, enrollees qualified for reprocess payments if, during the 2014 and 2015 benefit years, they paid more for services than they would have if the claims were properly processed as services provided by in-network providers. *Id.* To be eligible for reimbursement, Blue Shield required enrollees to prove they received the covered services, identify the specific

justments and included this amount in the MLR numerator, but it still fell below the eighty-percent benchmark.⁴⁴ As a result, Blue Shield paid an annual rebate to its enrollees.⁴⁵ Although the plaintiffs, Becky Ebenkamp and Rebecca Morris on behalf of over 446,000 enrollees, received an MLR rebate from Blue Shield, they claimed that they should have received a larger rebate because Blue Shield improperly included the claim adjustments from the settlement agreement as part of the incurred-claims numerator of the MLR.⁴⁶

The plaintiffs originally brought a putative class action suit in Los Angeles County Superior Court.⁴⁷ They alleged that, by treating the settlement payments as part of Blue Shield's incurred claims, Blue Shield violated state law prohibiting unfair competition and unjust enrichment.⁴⁸ More specifically, the plaintiffs alleged that Blue Shield's conduct violated California's Unfair Competition Law because it constituted an unlawful business act, unfair business act, and fraudulent business act.⁴⁹ The plaintiffs further alleged that Blue Shield was unjustly enriched at the plaintiffs' expense by retaining the

services they received, list the date of their visit, and confirm that either they paid the provider or the provider was actively seeking payment. *Id.*

⁴⁴ *Morris*, 918 F.3d at 1017; see 42 U.S.C. § 300gg-18(b)(1)(A)(ii) (stipulating the calculation for the rebate amount).

⁴⁵ *Morris*, 918 F.3d at 1017.

⁴⁶ *Id.* Blue Shield gave Morris an MLR rebate of \$118.72 and Ebenkamp a rebate of \$174.94. *Blue Shield*, 2017 WL 1653938, at *6. The plaintiffs sought damages on behalf of all enrollees in similar situations in the amount of \$34,941,646, which is the difference between the rebates that Blue Shield paid and those that it would have paid if it had not included the settlement payments. *Id.*

⁴⁷ *Morris*, 918 F.3d at 1017. The plaintiffs based allegations of miscalculation on a memorandum that Blue Shield released in 2016 stating that it paid \$44,596,201 in claims for payment errors in 2014. *Blue Shield*, 2017 WL 1653938, at *2. Blue Shield confirmed that the payment error amount included the settlement payments. *Id.* A class action lawsuit is usually brought by one or more named plaintiffs on behalf of a group of individuals, known as the class, who are similarly situated. Margaret M. Zwisler et al., *Overview of Class/Collective Actions and Current Trends*, LATHAM & WATKINS LLP 403, 405 (2015), <https://www.lw.com/thoughtLeadership/TheClassActionsGuide-US> [<https://perma.cc/9ZZ9-J5PC>]. A putative class action is a proposed class action because a court has not officially certified the class. *Id.* at 407. Once a court determines that the potential class, also referred as the putative class, has satisfied the requirements for a class action in Federal Rule of Civil Procedure 23(a), a putative class action becomes a class action. FED. R. CIV. P. 23(a); Zwisler, *supra* at 408.

⁴⁸ *Morris*, 918 F.3d at 1017–18; see CAL. BUS. & PROF. CODE § 17200 (2020) (defining unfair competition).

⁴⁹ Class Action Complaint for Damages, Declaratory and Injunctive Relief at 12–15, *Morris*, 918 F.3d 1011 (No. 2:16-cv-05914-JAK-JPR), 2017 WL 1653938, at *7. Plaintiffs claimed that Blue Shield acted unlawfully because it wrongly inflated its MLR, which resulted in it paying a lower rebate to the enrollees. *Id.* at 12. The plaintiffs claimed that Blue Shield engaged in an unfair business act because it included the restitution payments in its MLR in bad faith, made material and misleading omissions in how it calculated its MLR, and calculated the MLR in a manner that was not transparent or verifiable by the plaintiffs. *Id.* at 13. Furthermore, the plaintiffs claimed that Blue Shield engaged in a fraudulent business act because, by including the restitution payments the MLR, Blue Shield acted in a false and misleading manner to deceive the plaintiffs. *Id.* at 14. Lastly, the plaintiffs alleged that including the restitution payments violated the MLR provision because the ACA requires insurers to exclude erroneous claims payments from its calculation. *Id.* at 12.

difference between the rebate paid and the rebate amount that the plaintiffs believed they should have received.⁵⁰ Blue Shield subsequently removed the suit to the District Court for the Central District of California and sought dismissal of the complaint.⁵¹

The plaintiffs filed a First Amended Complaint (FAC) arguing that the settlement payments were restitution for payments for out-of-network services, not claims paid to in-network providers.⁵² Thus, the plaintiffs alleged that the settlement payments should not be included in the MLR's incurred-claims numerator.⁵³ Blue Shield filed a motion to dismiss the FAC, arguing that the settlement payments counted as incurred claims because they were for services that the insurance policies covered.⁵⁴ In response, the plaintiffs contended that, because the providers were out-of-network, the insurance policies did not cover the services.⁵⁵

After reviewing the settlement agreement, MLR statute, and regulations, the district court granted Blue Shield's motion to dismiss without leave to amend, reasoning that the payments were compensation for clinical services, regardless of whether the services were out-of-network.⁵⁶ The district court further reasoned that the plaintiffs' position was inconsistent with the definition of "incurred claims" as stated in the ACA.⁵⁷

⁵⁰ Class Action Complaint for Damages, Declaratory and Injunctive Relief, *supra* note 49, at 15.

⁵¹ *Morris*, 918 F.3d at 1018; *see* 28 U.S.C. § 1441(a) (2018) (allowing for the removal of a suit to a federal district court with original jurisdiction).

⁵² *Morris*, 918 F.3d at 1018. A first amended complaint alters the original complaint. *Amended Complaint*, BLACK'S LAW DICTIONARY (11th ed. 2019). Specifically, the plaintiffs alleged that the claim adjustments should have been included on Line 2.6 of Part 1 of the MLR Report rather than calculated as part of incurred claims because they were payment errors. *Blue Shield*, 2017 WL 1653938, at *2. Line 2.6 is for "any amount excluded from claims for MLR purposes that are normally included in claims for financial statement purposes." *Id.*

⁵³ *Morris*, 918 F.3d at 1018.

⁵⁴ *Id.*; *see* FED. R. CIV. P. 12(b)(6) (allowing a defendant to move to dismiss a case).

⁵⁵ *Morris*, 918 F.3d at 1018. According to the plaintiffs, only reimbursements for services by in-network providers should be considered in the MLR numerator. *Id.* at 1014.

⁵⁶ *See Blue Shield*, 2017 WL 1653938, at *8 (reasoning that the restitution payments compensated the insureds for clinical services, and thus Blue Shield was correct to include those payments as part of the incurred-claims numerator of the MLR).

⁵⁷ *Id.* at *6. The plaintiffs argued that the restitution payments were not required under the terms of the insurance policy. *Id.* Therefore, they claimed that the only payments that should have been included under the policy were reimbursements for claims at the out-of-network rate. *Id.* The district court noted that there was no provision that prohibits treating the restitution payments as incurred claims, even if they were above the amount required under MLR policies. *Id.* The court also looked to the ACA's definition of "incurred claims," which allows insurers to include the amount they spent on reimbursements for clinical services that were provided to enrollees. *Id.*; *see* 42 U.S.C. § 300gg-18(a) (stating the requirement for insurers to include reimbursements for clinical services under the numerator of the MLR). The court determined that services provided out-of-network fall within the ACA's definition of incurred claims. *Blue Shield*, 2017 WL 1653938, at *6; *see* 42 U.S.C. § 300gg-18(a).

The plaintiffs appealed, and the Ninth Circuit affirmed the district court's decision.⁵⁸ The Ninth Circuit held that the spirit and intent behind the ACA did not permit a narrow reading of the MLR provision to exclude payments for out-of-network services.⁵⁹ The court noted that Congress intended the ACA to expand health care benefits while reducing costs.⁶⁰ The court also emphasized the important role that the MLR provision plays in the ACA's goals of expanding health care coverage and decreasing health care costs.⁶¹ As such, the Ninth Circuit determined that, in order to discourage disputes and focus on lowering health care costs, all benefit payments, whether in-network or out-of-network, should be included in the MLR numerator.⁶²

II. THE PLAINTIFFS' ARGUMENTS AGAINST INCLUDING SETTLEMENT PAYMENTS IN THE MLR NUMERATOR

The crux of the plaintiffs' argument was that Blue Shield should not have included the payments for services that the insurance plan did not cover when calculating the MLR numerator.⁶³ First, the plaintiffs pointed to the statute that provides the types of expenditures that may be included in the numerator.⁶⁴ They emphasized that the language requiring insurance companies to report the amount they spent on incurred claims provided to enrollees "under such coverage" supported their argument that payments for clinical services must comply with the terms of the health insurance policy.⁶⁵ Because the health insurance policy did not cover the reimbursed out-of-

⁵⁸ *Morris*, 918 F.3d at 1014, 1018.

⁵⁹ *Id.* at 1019–20 (holding it unnecessary to strain the language of the MLR provision because the purpose of the ACA was to broaden access to health care and reduce costs).

⁶⁰ *Id.* at 1020 (explaining that the MLR provision incentivizes insurers to spend more on clinical services, which, in return, aids the expansion of health care coverage). The court also noted that the MLR provision helps to reduce health care costs because if an insurance company fails to reach the eighty percent requirement, policyholders are reimbursed the difference. *Id.*

⁶¹ *See id.* (reasoning that the MLR rebate lowers health care costs by reimbursing enrollees a portion of the premiums paid). The eighty-percent benchmark incentivizes insurance companies to maximize the amount spent on clinical services and activities that improve health care quality. *Id.*

⁶² *Id.* (explaining that Congress's emphasis on expanding coverage and benefits and reducing costs discourages insurance companies from spending premium revenue on administrative costs, such as those that come with disputes).

⁶³ *See* Opening Brief for Appellant at 19, *Morris v. Cal. Physicians' Serv.*, 918 F.3d 1011 (9th Cir. 2019) (No. 2:16-cv-05914-JAK-JPR), 2017 WL 5957481, at *xxii (arguing that the statute and regulations clearly show that insurers cannot include services not covered when calculating the numerator of the MLR).

⁶⁴ 42 U.S.C. § 300gg-18(a)(1) (2018) (providing that "reimbursement for clinical services provided to enrollees under such coverage" are included in the MLR numerator); *Morris*, 918 F.3d at 1018.

⁶⁵ *See* Reply Brief for Appellant at 1, *Morris*, 918 F.3d 1011 (No. 2:16-cv-05914-JAK), 2018 WL 1093773, at *1 (citing 42 U.S.C. § 300gg-18(a)) (arguing that there should be a distinction between in-network and out-of-network payments because the plain meaning of the statute indicates that payments for clinical services must be made to policyholders based on the terms of the policy).

network expenses, the plaintiffs contended that they should have been excluded from the MLR numerator.⁶⁶ Second, in the regulations that specify what qualifies as an incurred claim, the plaintiffs argued that the meaning of “covered by the policy” only includes in-network services and providers.⁶⁷ Therefore, the plaintiffs maintained that the statutory and regulatory text indicates that insurers may only include in the MLR numerator services that the insurance policy covers, in-network services, not all clinical services provided to an enrollee.⁶⁸

The plaintiffs also contended that under the current insurance system, whether a service is covered by the policy depends on if it is a covered benefit under the terms of the policy and the identity of the provider of the service.⁶⁹ Therefore, the plaintiffs argued that if there was no differentiation between in-network and out-of-network payments, insurers would be more likely to make payments outside the terms of the health insurance policy.⁷⁰ Similar to how Blue Shield passed the burden of the settlement payments onto its policyholders by lowering the rebate amount, future insurers could pass these costs onto its policyholders.⁷¹ The plaintiffs argued that this runs contrary to the MLR provision’s intent to reduce health care costs and promote efficiency because it could increase health care costs for enrollees.⁷²

⁶⁶ See Reply Brief for Appellant, *supra* note 65, at 2 (arguing that the “under such coverage” language only allows reimbursements outlined in the policy’s terms).

⁶⁷ 45 C.F.R. § 158.140(a) (2019) (providing that incurred claims include payments to providers “whose services are covered by the policy”); see Reply Brief for Appellant, *supra* note 65, at 4 (citing 45 C.F.R. § 158.140(a)) (contending that incurred claims exclude payments made for out-of-network services because the policy did not cover them).

⁶⁸ See Opening Brief for Appellant, *supra* note 63, at 19 (citing 42 U.S.C. § 300gg-18(a)(1)) (emphasizing that the reimbursement for clinical services is only provided if the service is “under such coverage”).

⁶⁹ See Opening Brief for Appellant, *supra* note 63, at 20 (citing Peter Kempter et al., *Insurance Product Design and Its Effects: Trade-Offs Along the Managed Care Continuum*, 30 INQUIRY 101, 102 (2012)). The plaintiffs also highlighted the difference between plan structures and provision and how they affect whether a plan includes a service. Opening Brief for Appellant, *supra* note 63, at 20. For example, EPOs only cover services provided in-network and do not cover any out-of-network services. *Id.* at 21. In contrast, coverage provided by PPOs may vary. *Id.* For example, some PPOs may provide certain out-of-network benefits while limiting other services, and others cover out-of-network services on an indemnity basis. *Id.*

⁷⁰ See Reply Brief for Appellant, *supra* note 65, at 3 (explaining how encouraging health care expenditures could incentivize insurers to spend premium revenue on services outside the policy’s terms because insurers can pass all those costs onto its policyholders).

⁷¹ See Opening Brief for Appellant, *supra* note 63, at 22 (arguing that if insurers could include more than just covered services as part of incurred claims in the MLR numerator, there would be no deterrence for future insurance companies to do the same and charge policyholders for the cost).

⁷² See Reply Brief for Appellant, *supra* note 65, at 3 (explaining how passing costs onto policyholders increases health care costs beyond the limit set forth in the policy).

The Ninth Circuit rejected the plaintiffs' arguments based on the court's analysis of the statutory and regulatory language.⁷³ The court reasoned that the statutory language, "under such coverage," focuses on insurance companies providing coverage for health services and only measures total expenditures on clinical services.⁷⁴ Therefore, the court determined that there was no reason to differentiate between the amount spent on in-network and out-of-network services.⁷⁵ Furthermore, the court determined that the regulatory language "covered by the policy" does not indicate that the provider must be in-network for the expenses to be part of the MLR numerator.⁷⁶ Rather, the court reasoned that the regulation, like the statute, does not distinguish between in-network and out-of-network providers or services.⁷⁷ Finally, the court determined that whether a service is covered by the policy is determined by the type of service, not any characteristic of the provider.⁷⁸

III. THE NINTH CIRCUIT PROMOTED THE INTENTION BEHIND THE ACA AND MLR PROVISION

The Ninth Circuit properly used *Morris v. California Physicians' Service* as an opportunity to promote the ACA's intention of decreasing health care costs and increasing efficiency in the health care system.⁷⁹ First, if the Ninth Circuit determined that there was a notable difference between in-network and out-of-network services, it would decrease efficiency in the health care system.⁸⁰ Drawing such a distinction would incentivize insurance companies to spend more time and resources determining if a reimbursement for clinical services could be included in the MLR calculation.⁸¹

⁷³ See *Morris*, 918 F.3d at 1019 (stating that none of the relevant federal laws supported the plaintiffs' argument that the settlement payments must be excluded from the MLR numerator).

⁷⁴ *Id.* at 1018–19; see also 42 U.S.C. § 300gg-18(a)(1).

⁷⁵ See *Morris*, 918 F.3d at 1018–19 (stating that only the total expenditure was relevant, because that is the critical focus of the MLR provision, not the relative amounts paid to in-network or out-of-network providers). In response to the plaintiffs' argument that clinical services must be within the policy's coverage, the court determined that the limitation is on the types of services that qualify and not the qualification of the health care provider. *Id.* at 1019.

⁷⁶ *Id.*; 45 C.F.R. § 158.140(a).

⁷⁷ *Morris*, 918 F.3d at 1019.

⁷⁸ See *id.* (reasoning that the nature of the services determines whether the service qualifies as "under such coverage," and not any qualification of the provider); see also 42 U.S.C. § 300gg-18(a)(1).

⁷⁹ *Nat'l Fed'n of Indep. Bus. v. Sebelius (NFIB)*, 567 U.S. 519, 538 (2012); see *Morris v. Cal. Physicians' Serv.*, 918 F.3d 1011, 1020 (9th Cir. 2019) (explaining that the MLR requirement and rebate together incentivize insurers to spend more of the premium revenue on health care and activities that improve the quality of health care).

⁸⁰ See *Morris*, 918 F.3d at 1020 (noting that the distinction would discourage payment of benefits even though the MLR is intended to expand health care benefits).

⁸¹ See *id.* (reasoning that drawing such a distinction would encourage disputes that may be costly for the insurance company). To dispute a claim, an enrollee could contact the billing department of the

Second, whether a service is considered in-network or out-of-network would increasingly become a source of contention between enrollees and insurance providers.⁸² With more of the premium revenue spent on resolving these disputes, insurance companies would use a lower percentage of the premium revenue for clinical services or improving the quality of health care.⁸³ For example, if another insurance company were to face a similar issue as Blue Shield, it is possible that it would face a similar dispute with policyholders.⁸⁴ Therefore, insurance companies would focus more resources on administrative expenses rather than clinical services.⁸⁵

Lastly, if the Ninth Circuit ruled differently, it would run contrary to the ACA's purpose and suggest that the intention of the MLR provision is to provide rebates to policyholders.⁸⁶ Rather, the purposes of the provision are to promote transparency through clear accounting for costs and ensure consumer value.⁸⁷ Policyholders only receive a rebate when an insurance com-

insurance company either through phone or writing. *Health Care: Resolving Billing Problems and Claim Denials*, UNITED POLICYHOLDERS, <https://www.upheld.org/pubs/health-care-resolving-billing-problems-and-claim-denials> [<https://perma.cc/Q873-8C3P>]. If the insurance company is unable to resolve the dispute, the enrollee can then file a formal review with the company that would require the insurer to conduct an internal review. *Id.* Additionally, if the internal review does not satisfy the enrollee, the enrollee can contact the state regulatory agency which would require the insurance company's information and participation. *Id.*

⁸² See *Morris*, 918 F.3d at 1020 (explaining that excluding payments for services provided out-of-network would encourage disputes similar to the case at hand). Insurance companies can provide discounted rates for in-network services because they negotiate with the providers. James P. Jacobson, *To Pay or Not to Pay, That Is the Question: Coverage Disputes Between Health Plans and Members*, 29 *HAMLINE J. PUB. L. & POL'Y* 445, 449 (2008). In special circumstances, a health insurance policy may approve in-network coverage for out-for-network providers if the insurance company determines that the in-network providers cannot properly treat the enrollee because of medical needs or a special condition. *Id.* at 449–50.

⁸³ See Jean M. Abraham et al., *How Has the Affordable Care Act's Medical Loss Ratio Regulation Affected Insurer Behavior?*, 52 *MED. CARE* 370, 371 (2014) (noting that an insurer can raise the MLR by decreasing administrative expenses and allowing more spending reimbursements for claims). In 2018, Blue Shield earned \$20.6 billion in revenue from premiums and spent \$2.3 billion on administrative costs. *Financials*, BLUE SHIELD OF CALIFORNIA, <https://bit.ly/35damUy> [<https://perma.cc/2QG4-G4RY>]. Excluding marketing and taxes, Blue Shield spent \$1.6 billion on general and administrative expenses. *Id.*

⁸⁴ See *Morris*, 918 F.3d at 1020 (noting that ruling in favor of the plaintiffs would encourage disputes similar to those in this case).

⁸⁵ See *id.* (explaining that affirming a distinction between payment for in-network and out-of-network services would not only limit the payments made for clinical services but also increase the costly disputes, and that the MLR provision expressly discourages the use of premium revenue for administrative costs). After the passage of the MLR provision, the individual market, small group market, and large group market reported lower total and per member administrative costs nationally from 2010 to 2011. Abraham et al., *supra* note 83, at 371.

⁸⁶ *NFIB*, 567 U.S. at 538; *Morris*, 918 F.3d at 1020. The Obama Administration implemented the ACA to address high health care costs and the high population of uninsured. AM. PUB. HEALTH ASS'N, *supra* note 18, at 1.

⁸⁷ 42 U.S.C. § 300gg-18(a), (b) (2018); see Scott E. Harrington, *Medical Loss Ratio Regulation Under the Affordable Care Act*, 50 *INQUIRY* 9, 10 (2013) (summarizing the stated goals of the ACA's

pany fails to spend eighty percent of its premium revenue on clinical services.⁸⁸ The rebate is a secondary measure because individuals who enroll in health insurance plans expect their insurance to cover health care costs, not to provide rebates.⁸⁹ Therefore, it would have been improper for the Ninth Circuit to suggest that the purpose behind the MLR provision was to provide rebates instead of insurance benefits.⁹⁰

CONCLUSION

Congress passed the ACA with two main goals: expanding health insurance coverage and reducing health care costs. The MLR provision furthers the goals of the ACA by requiring insurance companies to spend at least eighty-percent of their revenue towards clinical services and health care quality improvement. The numerator of the MLR is calculated by the adding the amount the insurance company spent on incurred claims and the amount it spent on quality improvement activities. The denominator is the total revenue collected by the insurance company less taxes, licensing fees, and regulatory fees.

The Ninth Circuit was the first federal circuit court of appeals to rule on whether there is a distinction between in-network and out-of-network services when calculating the incurred claims portion of the MLR. Based on statutes and regulations addressing the calculation of the MLR, the court held that out-of-network services may be included in the numerator of the MLR as part the insurance company's incurred claims. The Ninth Circuit noted that there was no indication in the ACA, whether in the writing or in the purpose of the ACA itself, to narrowly interpret the MLR provision.

MLR provision). Policyholders pay premiums every month to receive reimbursements from the insurance company or so that the insurance company pays directly for clinical services and other health care costs. *See Health Insurance*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/health-insurance/> [<https://perma.cc/QB6F-F2KM>] (defining "health insurance"); *Premium*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/premium/> [<https://perma.cc/93TR-PLGR>] (defining "premium").

⁸⁸ 42 U.S.C. § 300gg-18(a); KIRCHHOFF, *supra* note 6, at 2. HHS announced that in 2012, insurance companies issued \$504 million in rebates, compared to the \$1.1 billion they issued in 2011. KIRCHHOFF, *supra* note 6, at 2.

⁸⁹ *See* AM. PUB. HEALTH ASS'N, *supra* note 18, at 1–2. Specifically, health insurance provides financial protection for unexpected or serious injuries or illnesses and covers the costs of preventative services like vaccinations and screening tests. *Id.* Generally, the higher the MLR, the more value the consumer receives with their premium payments. *See* KIRCHHOFF, *supra* note 6, at 1. If a consumer receives a rebate because the insurance company failed to meet the benchmark, then the consumer receives less value for each dollar of paid premium. *Id.*

⁹⁰ *See* 42 U.S.C. § 300gg-18(a), (b); *Morris*, 918 F.3d at 1020; KIRCHHOFF, *supra* note 6, at 1 (explaining that health insurance is supposed to provide protection against financial risks that come with illness or injury).

The Ninth Circuit's reasoning is consistent with the purpose behind the ACA. In order to expand health care coverage and lower health care costs, the MLR provision should be read broadly and without a distinction between in-network and out-of-network services. The Ninth Circuit's broad interpretation discourages further disputes and refocuses the spending of premium revenue on clinical services and on improving the quality of the health care system.

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